Mad in America
SCIENCE, PSYCHIATRY AND SOCIAL JUSTICE

The Patient-Enemy: How Derrida Helps Explain Psychiatry's Cruelty and Care

By **Alex Conway** - July 9, 2024

In 1957, John Chapman published an article to the American Journal of Medicine titled "Peregrinating Problem Patients—Munchausen's Syndrome". The article describes his hospital's frustration in dealing with a patient who he calls a "professional hospital bum". The patient readmitted numerous times to the same hospital, suffering from an idiopathic bleeding disorder; however, upon further inspection, the hospital came to believe that his bleeding disorder was partially self-inflicted and partially fabricated. The man continued to plead for help and berated the doctors when they could not do anything more for him.

When I read this paper, I was struck by the animosity with which the patient is presented. He is continually insulted and demeaned. One physician describes him as "obese, obtuse, obstinate, obstreperous, and obscene". I was particularly taken aback by the passage which concludes the paper:

> "Such patients constitute an economic threat and an extreme nuisance to the hospital they choose to visit, for their deception invariably results in numerous diagnostic and therapeutic procedures… Appropriate disposition would be confinement in a mental hospital. Such patients have enough social and mental quirks to merit permanent custodial care."

There are many interesting implications of this paper. One being the simple fact that this invective was considered publishable medical research; but I would like to draw your attention specifically to the word "care". This word seems quite out of place in the article, particularly given that it is used in the context of recommending imprisonment. The care that is being offered does not sound altogether very "caring". How is one to interpret this strange blend of cruelty and care?

I think we can gain some insight from Jacques Derrida's work on hospitality. Derrida begins his study with an etymological analysis of the word "hospitality." The word is derived from the Latin "hospes," which roughly translates to "guest"; but "hospes" itself is derived from "hostis," which means "stranger", and from "potis", which means "master". "Hostis" is also the Latin root of the term "hostility." As such, Derrida observes "the troubling analogy, in their common origin, between 'hostis' as guest and 'hostis' as enemy, between hospitality and hostility".

The goal of this essay is to explore another troubling analogy—that which arises when we recognize that “hospital” also takes “hospes” as a root. To what extent is psychiatric hospitalization a legitimate hospitality for a sick person? And to what extent is psychiatric hospitalization simply a hostility towards a burdensome person?

For Derrida, the enmeshing of hospitality and hostility comes from what he calls “the question of the foreigner”. This question is asked on the macroscopic level of a threatened minority immigrating to a new country; and it is asked on the microscopic level of a down-on-his-luck man coming to stay at an old friend’s home. Derrida acknowledges a polysemy around this question. The foreigner arrives in a new land and has a question asked to him “How can we help you?” and by the simple fact of his arrival, asks an implicit question to the receiving town: “What are you going to do about me?”

The arrival of the foreigner motivates us to empathy. We all feel sympathy for a ship-wrecked man. Yet, at the same time the appearance of the foreigner also incites a sense of burden. We are concerned that the foreigner might overuse our resources or attack us. As such, the practice of hospitality becomes an awkward dance of kindness and cruelty. This dynamic establishes what Derrida calls the paradox of hospitality, a “hostipitality”. The ensuing inner conflict compels us to perceive the foreigner as a “guest-enemy”.

This dynamic can also be perceived as that old tension between the universal and the particular. Hospitality is idealized as an unconditional welcoming; but, in practice, the potential burdens and risks of the foreigner compel the host to proceed officiously and oppressively: “an antinomy then between the unconditional law of unconditional hospitality and the laws of hospitality, the always conditioned and conditional rights and duties of hospitality”. From here, we can expand our understanding of the “guest-enemy”. The guest becomes an enemy because of the psychosocial pressures surrounding his being welcomed as a guest. He is not coincidentally a guest and an enemy. He is an enemy precisely because he is a guest.

Now we can gain some insight into Chapman’s invective. At first glance it is odd that Chapman would not simply ban the problem patient from his hospital. Despite the indignation that Chapman suffered, the hospital readmitted the patient numerous times, undergoing the same cycle of bewilderment and

anger. But in light of Derrida's hostipitality, this behavior is coherent. It is a pride of the medical profession to provide services unconditionally to anyone in need. Perhaps then, Chapman felt obligated to treat the problem patient, but also resentful of this obligation. The disturbed man is therefore allowed to become a patient, but immediately resented for having been allowed to become a patient. He becomes the "patient-enemy".

Moreover, through the concept of the patient-enemy, perhaps we can better understand Chapman's recommendation of "permanent custodial care". By his medical dogma, Chapman is required to unconditionally treat any patient; but on the other hand, he resents the problem patient and wants him nowhere near his hospital. We now see the strategic usage of the psychiatric hospital. The psychiatric hospital serves as a vehicle by which one can punish an irksome man while at the same time appearing as though he is caring for him.

Chapman cites an incident in which the patient injured himself in protest of maltreatment: "He was ordered back to bed and threatened with physical restraints. This prompted him to withdraw to the ward utility room, where he inflicted a severe wound in his left thigh with a pair of scissors. He reappeared, sloshing blood at every step, storming up and down the hall, a terrifying spectacle. The tenor of his shouted remarks was, 'Now look what you made me do!'" It seems that the psychiatric hospital tacitly screams this same message back its patients: "Now look what you made me do!"

The Paradox of the Patient

Derrida continues by noting another inner conflict in which the foreigner is only welcomed to the extent that he is not actually foreign: "it is a hospitality that is not hospitable to the other as other, to the arrivant, but only to the foreigner furnished with a passport… whom my 'I can' can escort to the border at any moment if they encroach upon my right, my territory, my home, my ipseity, if they do not stay in their place… and do not behave according to the norms prescribed". We welcome the foreigner into our town, but only to the extent that he immediately adopts our customs and attitudes—only to the extent that he is not truly foreign.

It was eventually arranged for Chapman's patient to be committed to a psych ward; but the patient injured himself in protest: "Special arrangements were made for commitment to a state mental hospital, for psychiatric treatment was deemed mandatory… When he learned of these plans, the patient managed to leave his bed, procured a razor blade, and again slashed his left thigh, with another severe hemorrhage".

Here, we have a scene that is common to most psychiatric hospitalizations. A patient is committed to a hospital because he is perceived to be severely dysfunctional. However, the process of admission and the vicissitudes of psych ward life are difficult for even the most functional persons. Given that the patient is in severe distress, he is unlikely able to satisfy all of the institutional requirements (waking/sleeping on time, attending groups, engaging politely with staff etc). Nevertheless, upon the smallest transgression, he is immediately reprimanded, often with forced medications. As such, we see Derrida's strange paradox. The psychiatric patient is committed to a hospital because he is dysfunctional, but immediately upon entering the hospital, he is punished for the very dysfunction which originally motivated his hospitalization.

Of course, the biggest institutional requirement is the ingestion of medication. This requirement is quite ironic given the lack of empirical evidence for the efficacy of such medication (not to mention the growing body of evidence which suggests that such medication actually worsens suicide rates). Nevertheless, the patient is vehemently pressured into taking this medication – often suffering a punishment if he refuses (or simply a forcible injection). As such, it seems that we have, in addition to the paradox of the patient, a paradox of the medication. Medication that is known to be useless is forcibly demanded.

Perhaps this paradox too can be understood through the lens of hospitality. One of the most important customs across all cultures is the sharing of meals; and, as such, one of the most disrespectful behaviors a foreigner can exhibit is to spit out the food that his host serves him. Let us then interpret psychiatric medication as a quasi-meal. The patient is expected to gulp down and enjoy this meal, not because of any real health benefit that the meal might offer, but out of respect for the psych ward that is hosting him. If he refuses the medication, he is semiotically abasing the host and his home. And, as such, medication takes on a very strange reciprocal role in the hospitality relationship. Could it not be said that, by ingesting the medication, the patient is being hospitable? It seems that the hospitality of the psych ward comes with an expectation of a retrograde hospitality—that the patient welcome the medication into his body. And does the medication now also become a "guest-enemy"?

Perhaps the largest controversy in psychiatry is the alleged risks of medication. Let's take SSRIs, for example. Many psychiatrists maintain that this class of chemical is one of the safest interventions in all of medicine. On the other hand, many patients claim to have developed permanent neurological changes from exposure to these substances, such as sexual dysfunction and emotional blunting. The label "Post-SSRI Sexual Dysfunction" has been coined, and some preliminary research has begun. If this condition is indeed real (and I believe it is), why are psychiatrists so dismissive of it?

I think the dinner metaphor can help us here too. If we interpret medication in the semiotic context of a guest's banquet, then reporting a med-induced injury is tantamount to claiming to be poisoned by the dinner. The psychiatric patient is signaling that the host's cooking was so disgusting it poisoned him. Obviously, the patient isn't actually saying this—the patient just wants to be safe from harm—but that is how the hospital interprets him. As such, the psychiatrist not only denies the harm but is even offended by the suggestion of it.

And now we have a deepening of the paradox. The patient is required to take the medication—required to eat the dinner so as not to offend the host—and he might be harmed in doing so. Therefore, we have a situation where the patient, who was confined to a facility to stop him from harming himself, is now strangely required to harm himself.

Now let's return to Derrida. His next move is to expand upon the paradox of the foreigner by adding the concept of language:

> "He must ask for hospitality in a language that, by definition, is not his and is imposed upon him by the master of the house… The latter imposes translation into his own language upon the former, and that is the first violence. The question of hospitality starts there: must we ask the foreigner to understand us, to speak our language… before and in order to be able to welcome them into our home? If they already spoke our language, with all that that implies, if we already

> shared everything that is shared with a language, would the foreigner still be a foreigner, and could one speak of asylum or hospitality with respect to them?"

This linguistic dimension is particularly relevant to the psychiatric patient. Patients sometimes develop an idiosyncratic language to understand their struggles. In her memoir, *Because We Are Bad*, Lily Bailey describes her mental health symptoms as a hyper-developed imaginary friend:

> "For as long as I could remember, I wasn't me, I was we. Two of us sat side by side in my head, woven together, inseparable. She didn't even have a name; she was just She. Really, it was hard to say where She ended and I began. But food was not shared with her. She did not play tag and never required a seat. She was, by her very essence, nothing like these imaginary friends. She was just there. One was not proud of her, in the same way as one is not proud of a liver, and there was no need to show her off, nor tell anyone She existed."

Much later in life, Bailey was diagnosed with OCD and recovered by means of ERP therapy. However, like many patients, the treatment was turbulent and at one point she was committed to a psychiatric hospital. The care she received was neglectful and demeaning, inspiring this exchanged with the attending psychiatrist:

> "'It's YOUR fault!' I howl. 'YOUR fault I can't stop thinking about ice skates, because this treatment is WRONG. I wouldn't be thinking about ice skates if it weren't for YOU changing my medication and making me sit in huge groups of people…'"
>
> "'Lily,' Dr. Dax says slowly, 'have you ever considered the fact that you might be psychotic?'"
>
> "'I'm not! Dr. Finch said another doctor would say that! It's an intrusive thought, which of course you don't know anything about, because I'm not sure you even know what OCD is. GO AWAY!'"

In the hospital context, Lily is not allowed to talk about "Her"—that organ-like imaginary friend. Rather, she must learn the tongue of medical bureaucracy and speak of "psychosis". Although, in this case, Lily accepts a different diagnosis, OCD, many patients have a similar personal language to Lily, yet accept no psychiatric diagnosis. Nevertheless, for these patients to receive care, they must suppress their personal dialect and acquiesce to the rigid label offered by the psychiatrist.

A psychiatric consultant who examined Chapman's patient described him as "basically a psychopathic personality with overtones of paranoid schizophrenia". Do any of these labels actually mean anything? Do they elucidate the patient's bizarre and unique psychology—his game of fear and mutilation? Of course, not. But for the patient to be integrated into the psychiatric system, his lived experience must be trampled over by the codes of psychiatric bureaucracy.

The Pseudo-Prison and the Phantom Police

Derrida further elaborates his paradox by adding a spatiality. When a new ethnic group is welcomed into a city they are so often cordoned off into a sharply delineated subregion (Chinatown, Koreatown etc). "The question of hospitality," Derrida writes, "will often be posed according to the logic of the enclave, that is, of a place, an external territory enclosed in an interior … an inverse whose borders

separate an inside not from an outside but from the inside, and… make then of the most intimate inside the outside of the inside, an outside bolted up inside, under lock and key".

Derrida relates such an area to "la zone"—a French colloquialism similar in use to what we call "a bad neighborhood" (it is interesting to note how a similar enclaving occurs when a friend sleeps at your home—the guest bedroom becomes the "bad neighborhood" of the home). The foreigners are welcomed into the city but only on the condition that they are confined to a narrow zone with a militarized boundary. A psychiatric patient is admitted to the hospital as an ostensible medical patient —but he is not really a medical patient. He is quickly escorted off into a special area: a locked ward, poorly furnished, dilapidated, and equipped with a police presence. He is confined there and obviously not allowed to walk freely around the hospital. As such, the psychiatric hospital can be seen as the "bad neighborhood" of the hospital proper—a hospital inside the hospital, under lock and key from the real hospital.

As we come to understand the psychiatric hospital as a pseudo-prison, we must address the question of legality—the pseudo-laws which surround the pseudo-prison. Chapman believes that his patient has "enough social and mental quirks to merit permanent custodial care". Exactly which laws govern the propriety of social and mental quirks? Thomas W. Kallert published a chapter called "Mental Health Care and Patients' Rights—Are These Two Fields Currently Compatible?" in which he explored this topic. Kallert examined data on involuntary hospitalizations throughout Europe and found that the standards and practices were heterogeneous and vague:

> "A standardized legal analysis of civil law issues associated with involuntary hospitalization in psychiatric establishments… revealed major differences amongst the 12 European countries studied. Variations appeared in regard to basic conditions as well as additional criteria for involuntary admission, time periods for making decisions, the association between involuntary placement and treatment, patients' rights to register complaints, roles of relatives, and safeguard procedures of these processes."

Moreover, the regulatory bodies which are intended to supervise such hospitalizations are passive and deferential:

> "The general impression from these 12 European countries studied is that activities of supervising authorities are largely performed as formal routine. Supervision includes checking that paperwork is completed correctly and signed, but does not stimulate or demand practical changes… It seems that once the patient is placed in the hospital, the law delegates responsibility to the health professionals, and assumes that these professionals will always act in the best interest of the patient."

As such, psychiatry is enclaved into the legal system as a secret supplementary legal system—a legal system inside the legal system. This puts psychiatry in a situation similar to what Derrida calls "the phantom police".

Derrida comments on the legal ambiguities that surround the foreigner. He cites the example of Algerian Muslims who were once deemed "French nationals", but not "French citizens". Such ambiguity allows the police to become an autonomous authority.

> "They often let their police make the law. For example, the case is cited of a Kurd whose right of asylum had been officially recognized by a French tribunal and whom the police nonetheless expelled to Turkey without so much as a peep out of anyone…. this example raises or recalls the major, decisive problem of the police, the status of the police, a border police, but a police itself without border, without determinable limit, and one that is itself becoming omnipresent and spectral… police violence is then without figure or form, it is therefore without responsibility, it is nowhere tangible and in civilized states the specter of its ghostly presence is all-pervasive."

Right now, we are witnessing a new development of the phantom police. In 2020, the FCC voted unanimously to allocate hundreds of millions of dollars to the expansion of the national suicide hotline. The service was rebranded as the 988 Lifeline and now facilitates a network of over 200 call centers. Despite their ostensibly compassionate mission of providing "24/7 free and confidential support for people in distress", the Lifeline has disillusioned many callers with its policy of requiring police intervention in the context of "imminent risk" (a policy which is not disclosed to the callers).

Rob Wipond's recent article on Mad in America published interviews with two such callers. Both were deemed "imminent risk" by their Lifeline attendant, despite their protests that they just wanted someone to talk to. They then were given a non-consensual police/EMS visit, and were involuntarily hospitalized. One woman said: "It's traumatizing. It's a living nightmare". The other lamented: "I wasn't suicidal going in, but I sure was coming out."

SAMHSA attempts to downplay the situation by claiming that the rate of police/EMS intervention is only 2% (which is still alarmingly high). However, a recent survey of the data found that the average rate of police/EMS intervention was 7.8%; And Wipond suspects that the actual rate might be even higher, citing data from the New Mexico Crisis and Access Line: "only 27% of clinical calls involved people talking primarily about suicidal feelings, as opposed to work stresses, anxiety, substance abuse, or other concerns. People with suicidal feelings were targeted for coercive interventions much more frequently — in 15.1% of cases."

A policy document from Vibrant Emotional Health, the administrators of Lifeline, defines "imminent risk" as such: "if the crisis center staff responding to the contact believe, based on information gathered, that there is a close temporal connection (very short time frame) between the person's current risk status and actions that could lead to their suicide". It seems, then, that the attribution of imminent risk (and the legal consequences it entails) is contingent upon the call-attendant's capacity to assess the likelihood of suicide. How exactly do call-attendants make this assessment?

A recent SAMHSA document explains: "Draper and colleagues (2015) noted almost a decade ago that even though the 988 Lifeline's imminent risk definition is unique given the inclusion of core concepts from the Lifeline's suicide risk assessment standards (i.e., suicidal desire, intent, and capability), no research to date has evaluated whether the presence or absence of these factors influences near term suicide risk".

In other words, Lifeline has no reliable means to assess for suicide. They let the call-attendants make the law. Under the guise of "health care," we now have a diffuse network of call-attendant-judges haunting the phone lines, surveilling our quirks (looking for a sigh that is too long or a grunt that is too loud), and deploying police intervention if said quirks comport with a provisional and subjective

standard of "risk".

Wipond expands upon this controversy by examining the bizarre phenomenon of Lifeline affiliates selling suicide hotline call data to AI companies: "The for-profit company Protocall runs the New Mexico Crisis and Access Line 988 service (NMCAL) and, in partnership with Lyssn, a for-profit developing AI tools for behavioral health, received $2.1 million from the National Institute of Mental Health in 2023. Protocall and Lyssn are using recordings of 988 calls to create software that will purportedly 'evaluate the quality of crisis counseling' and teach call-attendants how to 'sharpen their skills'".

I looked into Lyssn and found this statement on their blog: "Lyssn AI already includes metrics that can identify when conversations about suicide have occurred during an interaction. However, we have not yet focused specifically on identifying indicators of risk, or specific interventions associated with risk reduction. It's certainly on our roadmap to continue building these sorts of tools". Perhaps, one day, Lyssn will come preinstalled on your iPhone. It will constantly evaluate your personal conduct against its statistical model of "risky" behavior and, if necessary, will automatically deploy a police presence to keep you "safe."

I think the psychiatric phantom police actually add a new dimension to Derrida's theory. Derrida's hospitality paradox always functions on a relationship of request-resentment. A foreigner requests asylum; it is granted, but he is resented for it. However, in the case of the 988 Lifeline, the victims did not request hospitalization; in fact, they actively protested it. Kallert notes that such repudiation of hospitalization is common among patients:

> "In a prospective clinical study in 11 European countries… 2326 consecutive patients admitted involuntarily to psychiatric hospital departments were interviewed within one week after admission; 1809 were followed-up after one month, and 1613 were interviewed three months later. The outcome criterion was whether the patient viewed the admission as appropriate. In the different countries, after one month, between 39% and 71% found the admission appropriate, and between 46% and 86% after three months."

From this research we see that, in some European countries, the majority of patients feel that their hospitalization was inappropriate even after the acute period of distress has passed. Nevertheless, despite not wanting hospitalization, patients are still despised as a burden to the medical system. Instead of the request-resentment relationship, psychiatry functions on a strange requirement-resentment relationship. Psychiatric patients are required to receive care, but then are strangely resented as burdens, simply because they are the subject of this requirement.

When Chapman's patient annoyed the hospital, the punishment was to move him to a locked psychiatric unit—in other words, to keep him in the hospital. When the patient then tried to escape the psych ward, the staff got even more annoyed. The hospital legally requires the annoying patient to stay at the hospital, which annoys it. Then, when the patient tries to escape, which would presumably alleviate the annoyance, the hospital gets even more annoyed and forces him to stay, so that he might annoy the hospital further.

Let me try to explain this bizarre situation with an analogy. Imagine an overbearing friend who notices

that you are suffering. The friend tells you that you should come stay at his home so that he can help you. You reject his offer, and he gets angry. He says that you are in desperate need of help. He threatens to fight you if you don't accept his offer. Alarmed, you concede and spend the night. When you wake up, he comes to the door and tells you, "Hey, you are kind of becoming a burden here, and I think you should start looking for your own place." At this point, even Derrida would scratch his head.

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Alex Conway

Alex Conway is a writer and former psychiatric patient interested in the intersection between philosophy and antipsychiatry. After becoming disillusioned by his own psychiatric treatment and by the treatment that members of his family received, he found solidarity in post-structuralist philosophy. He believes thinkers such as Foucault and Deleuze have great relevance to the criticism of psychiatry and hopes to bring these ideas to a wider audience. His work can be found on his blog: poststruct.com